ARTICLE

# GHOSTS AND ANGELS: INTERGENERATIONAL PATTERNS IN THE TRANSMISSION AND TREATMENT OF THE TRAUMATIC SEQUELAE OF DOMESTIC VIOLENCE

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ABSTRACT: The article discusses the impact of exposure to domestic violence on infants, toddlers, and preschoolers; the manifestations of post-traumatic stress disorder in the first years of life; and the parameters of Child-Parent Psychotherapy as a relationship-based treatment that aims at enhancing the parent's effectiveness as a protector as a means of restoring the child's momentum towards healthy development. Obstacles to the child's mental health and to the success of treatment are discussed, with particular attention to the adverse effects of parental psychopathology and of environmental stressors such as poverty, cultural marginalization, and lack of access to resources. It is argued that the infant mental health clinician working with traumatized children and their families needs to adopt a therapeutic approach that actively incorporates collaboration with other service systems, including pediatric care, childcare, law enforcement, child protective services, and the courts, in order to provide ecologically sound and culturally competent treatment.

RESUMEN: Este artículo discute el impacto que el estar expuesto a la violencia doméstica tiene en los niños, infantes y aquellos que aun no asisten a la escuela; las manifestaciones de un trastorno de tensión post-traumático en los primeros años de vida; y los parámetros de la Sicoterapia Niño-Progenitor como un tratamiento basado en la relación emocional, el cual busca mejorar la efectividad del progenitor como protector, a manera de restaurar la oportunidad del niño de tener un desarrollo saludable. Se discuten los obstáculos a la salud mental del niño y al éxito del tratamiento, prestándole atención particular a los efectos adversos de la sicopatología del progenitor y de las causas socio-ambientales del estrés, tales como la pobreza, la marginalidad cultural, así como la falta de acceso a recursos. Se sostiene que aquellos clínicos de la salud mental infantil que trabajan con niños traumatizados y sus familias necesitan adoptar un acercamiento terapéutico que incorpore activamente la colaboración con otros sistemas de servicios, incluyendo entre ellos al cuidado pediátrico, el cuidado a niños, la aplicación de la ley, los servicios de protección a la niñez, y los juzgados para proveer un tratamiento competente tanto desde el punto de vista ecológico como cultural.

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RÉSUMÉ: Cet article aborde l'impact de l'exposition à la violence domestique sur les bébés, les petits enfants et les enfants en maternelle, les manifestations du trouble de stress post-traumatique dans les premières années de la vie, et les paramètres de la Psychothérapie Enfant-Parent en tant que traitement basé sur la relation dont le but est d'améliorer l'efficacité du parent en tant que protecteur de façon à restorer le momentum de l'enfant vers un développement sain. Les obstacles à la santé mentale du l'enfant et au succès du traitement sont discutés, en portant une attention particulière aux effets négatifs de la psychopathologie parentale et des facteurs de milieu comme la pauvreté, la marginalisation culturelle et le manque d'accès aux resources. Nous soutenons que le clinicien en santé mentale de la petite enfance travaillant avec des enfants traumatisés et leurs familles a besoin d'adopter une approche thérapeutique qui incorpore activement une collaboration avec d'autres systèmes de services, y compris le soin pédiatrique, les crèches, la police, les services de protection de l'enfant, et les tribunaux de façon à offrir un traitement écologiquement solide et culturellement adéquat.

ZUSAMMENFASSUNG: Dieser Artikel diskutiert die Bedeutung des Erlebens von häuslicher Gewalt für Kleinkinder, die Manifestation der post traumatischen Stressstörung in den ersten Lebensjahren und die Parameter der Eltern Kind Psychotherapie als einer beziehungsbasierten Behandlung, die das Ziel hat die Fähigkeiten der Eltern als Schutzfigur zu verbessern, um so die Chancen des Kindes für eine gesunde Entwicklung zu erhöhen. Die Schwierigkeiten, die sich der seelischen Gesundheit des Kindes entgegenstellen mit besonderer Berücksichtigung der hindernden Effekte, die aus der elterlichen Psychopathologie und umgebungsbedingter Stressoren, wie Armut, kulturelle Randgruppen und eine Unmöglichkeit an Ressourcen heranzukommen stammen, werden besprochen. Es wird argumentiert, dass der Kliniker, der an der seelischen Gesundheit mit traumatisierten Kindern und deren Familien arbeitet, gezwungen ist einen therapeutischen Zugang zu wählen, der aktiv die Zusammenarbeit mit anderen Diensten beinhaltet, wie der kinderheilkundlichen Praxis, der Jugendwohlfahrt, der Exekutive, den Kinderschutzprogrammen und den Gerichten, um umweltbezogen richtige und kulturell kompetente Behandlung anbieten zu können.

抄録：この論文では家庭内暴力への暴露が乳児と幼児、そして就学前児に与える影響、生後１２か月までの外傷後ストレス障害の現れ方、そして子どもの健康な発達に向かう勢いを回復する手段として、親の保護者としての有効性を増強することを目指す関係性に基づく治療としての、親－子心理療法のパラメータを議論する。子どもの精神保健と治療の成功への障害物が議論される。特に、親の精神病理の悪影響と、貧困、文化的な周辺化および資源へのアクセスの欠如などの環境のストレスの悪影響が、注目される。外傷を受けた子どもとその家族の仕事をしている乳幼児精神保健の臨床家は、生態学的に健全で、文化的に適格な治療を提供するために、小児科のケア、保育、法的措置、児童保護サービス、および裁判所を含む他のサービスシステムとの協同を積極的に組み入れる、治療的アプローチを採用する必要があることが、議論される。

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This article has its origin in a plenary address I had the honor to deliver at the WAIMH conference held in Melbourne, Australia in January 2004. At the time, being invited to speak at this important event had set in motion a complex mixture of contradictory emotions, with pleasure vying with anxiety in a fierce competition for first place among the main ingredients

of my anticipatory experience. While the source of pleasure was, of course, self-evident, the main cause for anxiety was the uncertainty about what to say to an audience renowned for its understanding of the inner life of babies and young children.

And then serendipity made its wondrous appearance. During a rainy weekend dutifully set aside for writing (a weekend that was perilously close to the scheduled date for my talk), I came across a book by the renowned cartoonist Gary Larson: "The Far Side Gallery 4" (FarWorks, 1993). On the first page he wrote: "When I was a boy, our house was filled with monsters. They lived in the closets, under the beds, in the attic, in the basement, and – when it was dark – just about everywhere. This book is dedicated to my father, who kept me safe from all of them".

Suddenly I knew what I wanted to say. Larson's loving tribute to the protective role of a good father stands in stark contrast to the experiences of the traumatized children who infant mental health practitioners encounter every day, children who witnessed domestic violence and whose fathers and mothers create rather than slay the monsters they fear. Gary Larson had the good fortune of being haunted by monsters formed by his own imagination. The epic fight against these fantasized monsters is an essential rite of passage that in the course of normal development enables young children to do battle with their darkest and most powerful impulses and fears, and to eventually establish some kind of truce with them, by enlisting the protective powers of their parents as allies in this life-or-death psychological struggle. The proverbial "good enough" parent knows that children's fears are real even when the reasons the child gives for the fear may be imaginary, and the supportive parental response aims at shoring up the child's trust that he or she will not be left alone to contend with the danger.

The spooky world of imaginary monsters and witches is a parallel universe in which all humans regularly spend some time throughout the course of our lives, but it is most densely populated in infancy and early childhood, "the magic years," as Selma Fraiberg (1959) brilliantly called them, when fantasy is more developed than logic and children believe that their thoughts and behaviors make things happen in the outside world. However, for children growing up in violent households, the tried-and-true archetypal monsters of fantasy and myth are not only symbolic representations of forbidden wishes and untamed impulses. They carry the additional and terrifying immediacy of the parent's image, shattering the child's expectations of security because, **in reality and not just in fantasy**, the protector unexpectedly becomes the attacker, and there is nowhere to turn for help. To help these children in therapeutic work, it is essential to focus on the convergence between traumatic stressors and developmental and interpersonal processes, and to situate the focus of therapeutic attention on the dynamic interplay between external events and the child's individual adaptation to these events that create each child's unique constellation of strengths and vulnerabilities.

## RESPONSES TO VIOLENCE IN INFANCY AND EARLY CHILDHOOD

Two clinical vignettes illustrate this convergence of internal and external dangers so clearly articulated by Freud (1926/1959) at the beginning of his work. Mario, a 4-year-old boy, articulated the unconscious equation between parent and attacker during a session with his mother. One year earlier, when he was three years old, Mario had seen his mother pull a knife on his father, but this event had never been verbally acknowledged between mother and child. He was now telling a dream to his mother and their therapist when he had a slip of the tongue

and said: "I dreamed there was a mommy…. No, I mean, a monster, and he had this grey knife… and it cut me right here, it cut out my heart….. I called out for you to come help me, mommy, **but you did not come.**" In creating this amazing dream, Mario found a compelling way of expressing the two sides of his internal drama: his mother was not only a source of external danger but was simultaneously absent in her duty to protect. For her son, the developmentally expectable fears of loss, loss of love, and body damage merged in response to the threat represented by the attachment figure's simultaneous aggression and failure to protect.

The second example involves Sophia, a child who blamed herself for what happened to her mother and became severely stunted in her developmental progress after witnessing her mother being brutally mugged and nearly raped by an intruder as they were coming into their home. The attack had occurred when Sophia was 30 months old. She was referred for treatment a year later, at 42 months, because she had become progressively more fearful and socially withdrawn. For the first months of treatment, she spent session after session either enacting violent scenes using stuffed animals or building fortresses with the furniture of the playroom and hiding inside, allowing herself to be coaxed out only after repeated reassurances by the mother and the therapist that they would protect her and that she and her mother were now safe. An outgoing, bright, and verbal child before she witnessed her mother being attacked, Sophia had become increasingly sad, anxious, and monosyllabic after this event. After many therapy sessions in which issues of danger and protection were enacted again and again, she whispered: "He came in because I did not close the door." It is unclear whether this little girl had blamed herself for the attack on her mother right away, or whether she had gradually constructed this scenario over the course of the following year in her age-appropriate self-referential efforts to give meaning to this terrible event. Regardless of the timing, her self-blame had contributed to a paralyzing fear of talking and acting, and she could only confess to what she perceived as her "sin of omission" when she finally gave credence to the reassurances that her mother and her therapist provided by helping to create a protective outcome to her repeated reenactments of the traumatic event.

It is worth highlighting that Sophia's mother had been in psychiatric treatment for one year immediately following the attack, and she consulted with her therapist about the child's symptoms in the course of her own treatment. The psychiatrist advised her not to talk with Sophia about the attack and reassured her that the child was so young that she would soon forget what she had witnessed. Predictably, this wishful course of events did not take place and Sophia's symptoms intensified before she was due to start preschool, perhaps in anticipation of the impending daily separation from the mother that this would entail. It was then that a friend told the mother about "a new program" that was geared to treating young witnesses of violence, and the mother called to request treatment for her child. One year (almost one third of the child's life) of suffering and developmental derailment could have been avoided if the adult psychiatrist had been informed of the importance of timely infant mental health intervention. This example, unfortunately only too frequent, highlights the importance of ongoing outreach and dialogue with mental health professionals working with adults and with other service providers about the adverse consequences of early trauma and about the importance of timely intervention for the child's developmental course (Lieberman & DeMartino, 2006; Osofsky, 2004). One of the urgent tasks facing infant mental health clinicians is to disseminate to parents, teachers, primary care providers, and others who come in contact with young children an awareness of the importance of "listening to fear" (Marans, 2005), as expressed, often nonverbally, through the young child's behavior.

These clinical examples show two young children using very explicit words to describe how they arranged their inner worlds to give meaning to the violence they witnessed. What can we learn from them about the subjective experience of infants and toddlers who cannot yet speak? It is admittedly risky to extrapolate retroactively from later development to earlier internal processes, but the co-occurrence of mental states involving helplessness, terror, anger, emotional withdrawal, and dissociation seems to start as early as the first weeks and months of life among many children referred for treatment after witnessing domestic violence or subjected to maltreatment. Infants only three weeks old may demonstrate incessant crying after exposure to domestic violence. Infants aged nine months may slap the mother's face, not in the playful way in which infants tend to explore faces but with what looks like a purposeful strike. One- and two-year-olds often flee into their mother's arms sobbing uncontrollably only to bite her face, breast, or chest once they are being held by her. As Freud (1926/1959) first pointed out in his discussion of early trauma, the exposure to violence in the first years of life engenders profound helplessness and terror, and these forms of emotional dysregulation are causally linked to the shattering of the protective shield represented by the child's trust in the parent's competence as a protector.

While the young child's effort to cope with the shattering of trust following a traumatic event may change in its specific manifestations depending on the child's temperament and developmental stage, there are remarkable similarities of response across individual children. These responses have been organized into the diagnostic category of Posttraumatic Stress Disorder in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R; Zero to Three, 2005). The diagnosis resembles in major ways the diagnostic criteria for Posttraumatic Stress Disorder outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000), but it is tailored to the specific ways in which children in the first five years of life respond to traumatic events. The DC: 03R manual describes three basic clusters of symptoms: *Re-experiencing of the traumatic event*, manifested by post-traumatic play, repeated recollections outside of play, nightmares, distress at reminders of the event, and episodes with features of flashback or dissociation; *Numbing of responsiveness*, including increased social withdrawal, loss of previously acquired developmental skills, restricted range of affect, and constricted play; and *Increased arousal*, manifested in night terrors, difficulty going to sleep, repeated night wakings, hypervigilance, decreased concentration, and exaggerated startle responses. Associated features of the condition are the temporary loss of previously acquired developmental skills and the appearance of new symptoms that were not present before the traumatic event, such as new fears, aggression, and age-inappropriate sexual behaviors. It is worthwhile noting that in the earlier version of the DC:0-3 (Zero to Three, 1994), loss of developmental skills and new symptoms were listed as integral components of the diagnosis rather than as associated features. Existing research on this diagnostic question is still scarce, and it is likely that the diagnostic category will continue to be refined in response to new empirical findings.

Children showing traumatic stress behaviors are exceedingly difficult to live with.

They are demanding and often unpredictable, shifting rapidly between intense neediness and uncontrolled aggression. How do we understand the meaning of these behaviors? In the case of infants, toddlers, and preschoolers who witnessed domestic violence or were maltreated by their parents, children face an intractable dilemma because the parents are at their most frightening precisely when the child most needs them (Main & Hesse, 1990). Watching

the mother being battered by the father, the child may wonder: "If mommy can't protect herself, how can she protect me? If something happens to mommy, what will become of me? Who will take care of me?" When the violent father is out of the home due to marital separation or divorce, the child's longing for the loving aspects of the father gets mixed up with the fear of the father's destructive parts and the fear of being like him. We hear 2-, 3-, and 4- year-olds say to their mothers: "I will kill you"; "I will beat you up"; "I will call daddy and ask him to kill you because you are bad." In making these statements, the child's identification with the aggressor needs to be understood in the way Anna Freud Freud (1936) intended it to be: as the child's desperate attempt to be like the aggressor in order not to become victimized by him.

Perhaps the greatest challenge for therapists as well as parents is to understand the paradox that rage is often a response to helplessness, and that the child's aggression is often an effort at self-protection in response to perceived danger. One of the long-lasting consequences of traumatization, both for children and for adults, is that the world ceases to be predictable and the person cannot distinguish reliably between safe and dangerous environmental conditions. For infants, toddlers, and preschoolers, who rely on the attachment figure as the provider of predictability and protection, the first casualties of exposure to violence are the child's reliable expectations about what is safe and what is dangerous. As a result, the experience of violence triggers and exacerbates the primordial anxieties of the first years of life first identified by psychoanalysis: the fears of abandonment, loss of love, body damage, and superego condemnation (Freud, 1926/1959; Pynoos, 1995).

The unpredictable, disorganized behavior of traumatized young children is a reflection of the rapid shifts in their perception of safety and danger in response to inner states of mind and external stimuli. What looks "unpredictable" for the observer has a profound inner logic for the child. The therapeutic challenge is to unlock the mystery of that subjective logic in order to make an emotional connection with the child and to help the parent become the primary agent of protection as a means of promoting or restoring secure attachment. In addressing the child's behavior, the therapist needs to hear the underlying worry that the child is begging the clinician to disconfirm. These questions invariably involve key questions about the child's safety, lovability, and inherent goodness: "Will you hurt me the way you hurt mommy/daddy? Am I dangerous like my daddy? Will you, mommy, let me do the things that daddy did to you? What will happen if I am like daddy? Will I hurt you and kill you? Will you make me go away the way you made daddy go away?" The child's questions, whether articulated verbally or enacted through play and behavior, are not rhetorical. They have a powerful existential immediacy because the events to which they refer already happened and can happen again at any time. Notably, several 3- and 4-year-old boys raised by their single mothers after witnessing severe domestic violence perpetrated by their father against their mother expressed the wish to be a girl and were adamant in their position that they did not want to become men when they grew up. These boys equated being male with being violent and with being rejected and abandoned by their mothers, just as their fathers were. When both parents engage in violent behavior, the child does not have access to either parent as an object of "identification with the protector" (Lieberman, Padron, Van Horn, & Harris, 2005).

## THE PARENT AS ALLY IN THE CHILD'S TREATMENT: OPPORTUNITIES AND OBSTACLES

Children struggling with the profound emotional dislocation evoked by violence need to be reassured that, even when they are being aggressive, they will not be abandoned, they will be protected from harm, and they will continue to be loved. A useful therapeutic strategy to convey this message is to remind the child and the parent that the child is very young and in the beginning stages of learning what is safe and what is dangerous, what is allowed and what is forbidden, what is right and what is wrong. When the child witnessed one or both parents as the perpetrators of violence against each other and imitates parental aggression, a turning point in the treatment can occur when the therapist points out that the parent(s) did not learn the important lesson of how to be angry without hurting others while growing up. Helping the child and the parent learn how to express anger safely can then be articulated as one of the explicit treatment goals; can then become helping the child and the parent learn how to express anger safely.

Parents who are themselves traumatized by their past and/or present circumstances may resemble their children in the inability to distinguish reliably between dangerous and safe situations. As a result, they may be inconsistent guides in helping their child acquire a sturdy sense of reality and of socially appropriate behavior. Themselves frightened and uncertain, the parents may be unable to detect the anxiety underlying the child's aggression and incapable of providing reassurance while setting clear standards for permissible and impermissible child behavior. When their child becomes aggressive or defiant, traumatized parents often become punitive in response to the concrete threat they perceive in the child's behavior.

The dilemma of how to respond to child aggression is by no means limited to traumatized or inept parents. Stern (1985) discussed the paradox that maternal attunement to the child's negative affect might involve mirroring the negative affect, with maladaptive consequences that are antithetical to the theoretical construct of attunement. Child aggression is perhaps the most challenging behavior for therapists, who as part of their professional identity strive to remain attuned to the child's internal states. Many therapists find themselves, in the heat of the moment, responding to young children's aggressive behavior at face value by taking steps to stop the behavior while engaging in psychoeducational efforts to teach the child about the social unacceptability of aggression. Other therapists opt for labeling the feeling of anger underlying the aggressive act, hoping that interpretation will promote insight which, by itself, is expected to defuse anger and promote affect regulation.

We know, however, that neither psychoeducation nor interpretation and insight necessarily lead, by themselves, to more adaptive behavior. A more complex set of coordinated therapeutic interventions is needed to help the child experience, tolerate, and express intense negative affect without harming him/herself or others. These coordinated therapeutic interventions include taking concrete steps to contain the child's aggressive action when it threatens the safety of the child or others, while at the same time identifying the situational or internal trigger for the behavior, engaging the child in a process of recognizing the internal state that preceded the aggressive action and the function that the aggressive action was intended to serve, and helping the child to find and practice alternative behaviors that could fulfill the same function in a socially acceptable manner. It is seldom that a therapist has an opportunity to seamlessly apply the different steps in this sequence in response to a single

incident, but the cumulative effect of discrete efforts can cohere across incidents and sessions to convey a consistent approach to the understanding and management of dysregulated behaviors and the internal states that give rise to them.

The therapist's efforts to enlist the parents as allies in the treatment may falter even in the presence of a coherent therapeutic strategy. For example, a battered woman may respond to her small child as if the little one were actually her abusive partner, unwittingly reinforcing the child's traumatic stress behavior through her response to it. As an illustration, an 18-month-old living with his mother at a battered woman's shelter lifted his arms towards her after being pushed to the ground by another child. The mother, fresh from a battering experience a few days earlier, yelled at him: "Don't you hit me!" He burst into tears and threw himself down, hitting his head on the floor again and again. This mother had misinterpreted her child's outstretched arms, seeing them not as a plea for help but as the prelude to an assault. The child, in turn, was in the process of internalizing the mother's negative attributions and punishing himself for his self-perceived "badness." When the clinician gently explained that the child was actually signaling for help, the mother turned to her sharply and said: "Well, then, you are the expert. You help him."

This mother's stance illustrates one of the major challenges of therapeutic work with traumatized children and their parents. Mothers and fathers who are themselves worn out and overwhelmed by the combination of traumatic events and difficult life circumstances do not always welcome the clinician's efforts to help them respond to their children's needs. Nevertheless, in the long run, individual psychotherapy with the child may be of limited value because the parent-child relationship provides the core of the child's sense of self and trust in others, and this core—whether primarily positive or negative in its affective valence—will remain in place long after treatment has been terminated and the therapist has left the scene.

## A MODEL OF RELATIONSHIP-BASED TREATMENT

Child-Parent Psychotherapy (CPP) was developed as a treatment approach to address the complex interface between traumatized children and traumatized parents (Lieberman, 2004; Lieberman & Van Horn, 2005). While originating in psychoanalysis (Fraiberg, 1980) and attachment theory (Bowlby, 1969, 1973, 1980), it has become a metatheoretical approach through the integration of different theoretical orientations and simultaneous attention to states of mind, schemas of the self and other, interpersonal processes, social roles, the impact of behavior on internal experience, the impact of stress and trauma on personality formation, and cultural values and mores regarding each one of these domains (Bronfenbrenner, 1979; Cicchetti & Lynch, 1993; Cohen, Mannarino, & Deblinger, 2006; Horowitz, 2003; Pynoos, Steinberg, & Piacentini, 1999). The basic premise of CPP is that treatment should focus on creating or restoring a sense of trust and safe intimacy between parent and child by recreating comfort with body-based sensations, confidence in the parent's willingness and capacity to protect from external danger and emotional dysregulation, and interest and pleasure in engagement with age-appropriate activities. In situations where both the parent(s) and the child are traumatized, the therapist's focus of attention needs to hover evenly among all parties, giving the child's mental health needs pride of place as the ultimate goal of treatment but moving flexibly between the child's mental state and the parent's mental state in order to translate each partner's individual experience to the other and to maximize the opportunities to promote mutual understanding between parent(s) and child.

### *Clinical Vignette*

A session with Mario illustrates CPP practice. This particular session transpired four months into the treatment, which in this case took place in the home. The CPP therapist brings to the home visits a set of toys chosen to evoke the specific traumatic event experienced by the child as well as toys with neutral content to promote age-appropriate play. On this occasion Mario was playing with the kitchen set. He suddenly lifted a kitchen knife and said to his mother: "Look, mommy, here is the knife of my dream." He then told the clinician that he had had a "very, very bad dream." She asked him what the dream was about, and he said: "This knife was in my dream," adding: "There was this mommy, no, this monster, and he had this grey knife, just like this one, and it cut me right here, it cut out my heart." The mother asked tentatively if she appeared in the dream, and Mario replied "No, you weren't. I called you to come help me, but you did not come." The therapist commented that it sounded like a very scary dream, and Mario agreed that it was. The mother then explained that Mario had screamed in his sleep, she could not wake him up, and that she had never seen him so upset. He had slept in her bed for the rest of the night.

This episode needs to be put in the context of the violent scene that Mario had witnessed a year earlier, when the mother threatened the father with a kitchen knife. The mother had reported this scene to the therapist during an individual assessment session before the beginning of treatment, but she had never spoken with Mario about this event. Wanting to enlist the mother's support in helping Mario to describe his experience of this traumatic event, the therapist made a detour from attending to the child's dream and asked the mother: "Are you a little mad at me that I have a knife among the toys I bring here?" The mother replied: "At first I was mad, but then I thought that this is why we are in therapy, because he needs to talk about things, but it makes me feel guilty that I frightened him so much." The therapist responded that she understood the mother's mixed feelings and commented that all parents wish at times they could turn the clock back and do things differently. She added: "Unfortunately one can't turn the clock back, but one can do what you are doing now, which is to try to help Mario make sense of what happened so that he is not so scared by it." Feeling supported by this nonjudgmental comment, the mother turned to Mario and said: "Mario, I think you are thinking of the time that I pulled the knife out on your daddy." Mario looked at her seriously but did not say anything. The mother added: "You are too little to understand this, and I will tell you again when you are older, but I was very mad at your daddy and I am very sorry I scared you so much." Mario moved closer to her and said: "Sometimes you get really angry at me, mommy." The mother was taken aback and looked helplessly at the therapist, who said: "I know that when your mommy gets very angry it can be very scary. But your mommy loves you very much, and she will never take out a knife on you, no matter how angry she gets." The mother had tears in her eyes. She said: "Mario, I love you so much that I am very sorry you saw me do that, and I promise I will never, ever do something like that to you." Mario smiled slightly, turned to the doctor's kit, and tried all the medical instruments on his mother, his baby brother, and the therapist. After a while, the mother asked him: "What about the knife?" Mario answered: "I'm finished with the knife right now, mommy. You can put it away."

This example illustrates the judicious therapeutic use of a traumatic reminder, in this case the knife, which in Mario's dream cut out his heart but which in the therapy session could be restored to a semblance of normalcy as an everyday object through a detailed and emotionally

charged process of evoking the scene of marital violence that continued to haunt Mario a full year later. One of the goals of all therapies addressed to trauma is to help differentiate between reliving and remembering. Mario **relived** the traumatic scene in his dream; in the therapy session, he was enabled to **remember** it. He was also reassured that his mother was aware of the fear he had experienced and would not expose him to a similar danger again.

The therapeutic goal in the treatment of trauma in infancy and early childhood is for the parent to serve as the therapeutic agent because the parent is the person primarily responsible for the child's safety in everyday life. Moreover, doing this work on behalf of the child gives the parent the motivation to strive towards greater impulse control and better modulation of emotion. In analyzing the therapist's interventions in the above vignette, one may disagree with her taking the initiative in reassuring Mario that his mother would not pull a knife on him. One may argue that the therapist should not speak for the mother because the therapist could not know that the mother would not repeat her aggressive behavior in the future. In support of this intervention, on the other hand, is the importance of conveying to the mother the societal expectation that she should contain her aggressive impulses. Interpreted in this light, the therapist's intervention is a form of ego building to enhance the ability to cope with problems of emotional and behavioral dysregulation.

There is empirical evidence that mothers who have experienced domestic violence may be more harshly punitive with their children, as attested by the increased incidence of child abuse perpetrated by battered women (Osofsky, 2004; van der Kolk, 1987). Battered mothers also tend to underestimate or negate the extent to which their children witnessed domestic violence. This under-reporting is most likely a defense against guilt and a by-product of the mother's preoccupation with physical integrity during violent encounters, which diverts her attention from the child's experience (Pynoos et al., 1999; Peled, 2000). These findings underscore the importance of addressing parenting difficulties in the context of providing treatment for children with clinical problems stemming from exposure to domestic violence.

Given the multiplicity of risk factors conducive to domestic violence and stemming from it, effective intervention is only possible when it is tailored to the particular needs of the child in the context of the family circumstances. Many children referred for treatment as the result of exposure to domestic violence or maltreatment live, by definition, in dangerous and chaotic circumstances. Their parents, already beleaguered by their personal problems, may feel suspicious of the motivations prompting the referral, angry at being subjected to the scrutiny of outsiders, and fearful that the child will be placed in foster care on the grounds of maltreatment.

Parental resistance to the child's treatment may be compounded by the stress of external factors when the parents are poor, uneducated, and belong to ethnic and cultural groups with histories of oppression, discrimination, and disempowerment, for whom "social services" have historically become a code word for authoritarian expectations and punitive measures. Some parents may resent the referral because they are overburdened by the stresses of everyday life, and regular attendance to treatment would interfere with or compound the burden of work and household duties. Other parents may find themselves in competition with the child, envious that their child is deemed worthy of therapeutic attention while their own emotional needs remain unrecognized and unaddressed. Under these conditions, the child may become the target of parental blame for prompting the referral for treatment or for getting something that the parent wants but does not have.

When parental perceptions and needs are not integrated into clinical efforts to respond to

the child's needs, the parents may fail to bring the child to treatment or they may co-opt the goals of treatment in other passive or active ways, including criticizing and demeaning the therapist to the child. One mother spoke for many others when she explained her reluctance to participate in treatment by saying: "Therapists think that the child is always right. They spoil the children, and they blame the parents when we teach right from wrong. Then our children don't pay attention to us, and they threaten to tell the therapist when we try to make them obey." This mother felt deprived of her parental role and personal dignity by her experiences with the mental health system, which became a ready-made object for a negative institutional transference reaction based on long-standing and pervasive experiences of being unimportant and uncared for, both in her family and in society. It is impossible to know whether she was factually correct in believing that her child's previous therapist favored her child and took a position against her. What is clear is that the former therapist, for whatever reasons, did not succeed in engaging this mother as an indispensable partner in her child's treatment. Forming a working alliance with the parent on behalf of the child is an indispensable prerequisite to effective child treatment. With parents who are stressed and perhaps traumatized by their personal circumstances, such an alliance usually requires the clinician's empathy, support, and willingness to include the parent's individual concerns in the therapeutic sphere.

## PARENTS' PSYCHOLOGICAL FUNCTIONING

Helping the parent to become an ally in the child's treatment requires attention to the parent's personality structure and mental health status. Clinical interventions made on behalf of the young child can only be effective if they are tailored to the parent's ability to implement them by becoming more empathic towards the child's inner experience and by adopting more developmentally appropriate childrearing practices. "Relationships affect relationships" (Emde & Sameroff, 1978), with the result that the therapist's ways of relating to the parent have a profound influence on the parent's modes of relating to the child and on the child's ways of relating to the parent. The clinician's interest in the parent as an individual and not only as a parent gives the parent a sense of self-worth as a person that is often absent from his or her experience. The parent's helplessness and despair when feeling neglected by the therapist were genuinely expressed by a mother who exclaimed: "I know that my fantasy of putting my daughter in the steps of a church and walking away is rooted in what happened to me when I was little. But I am not only a mother, and I feel suffocated by having to attend to her all the time. I need time for myself, and I never seem to get it." This internal experience illustrates the shortcomings of insight alone, when not linked with proactive action to defuse deeply entrenched and potentially destructive patterns of feeling and behaving.

Giving parents opportunities—through individual collateral sessions, telephone sessions, or in the course of joint child-parent sessions—to narrate their own past and present circumstances and the feelings associated with them enables the clinician to appreciate the role that the parent's conflicts and defenses may play in the etiology and perpetuation of the child's mental health problems. Encouraging the parent to remember and utilize positive, self-affirming relationships and experiences may expand the parental repertoire of adaptive coping strategies and instill hope that the future for the child and the parent need not mirror the parent's painful past. The interplay of "ghosts in the nursery" (Fraiberg, 1980) and "angels in the nursery" (Lieberman, Padron, Van Horn, & Harris, 2005), represented by the intergenerational transmission of pathogenic and benevolent early experiences, can be a powerful predictor of the likelihood of treatment success when skillfully addressed by the therapist.

Parents' psychiatric disturbances and substance abuse problems can seriously interfere with their capacity to support or participate in their child's treatment. Whenever clinically appropriate, individual treatment for the parent needs to become a therapeutic priority and a focus of the intervention on behalf of the child. This is often a difficult enterprise, particularly for parents who lack financial resources or who belong to disenfranchised ethnic and cultural minorities that may not have access to treatment by culturally and linguistically competent service providers. In addition, the lack of integration between the adult mental health system and the child mental health system makes it exceedingly difficult to coordinate treatment for the child and the parents. Treatment for children and adults is provided by different agencies with separate locations, policies, funding resources, eligibility requirements, fee structure, and clinical orientation. When the parents and the child are traumatized by the same events, it is rare to find agencies that can address the needs of the different family members in a coordinated manner. The child clinician must strive to secure appropriate mental health or substance abuse intervention for the parents when their psychological functioning is so impaired that it affects the child's capacity to benefit from treatment. Clinicians working with traumatized young children seldom have the luxury of focusing only on the child. They need to expand the boundaries of their professional role and define their work as encompassing not only the treatment of the child, but also collaboration with other service systems to ameliorate the environmental stresses impinging on the child's healthy functioning (Harris, Putnam, & Fairbank, 2006).

## ASSESSING AND ADDRESSING THE DANGER OF CONTINUING VIOLENCE

The ongoing risk of domestic violence is a formidable obstacle to effective treatment. When treatment is provided after the traumatic situation no longer exists, the goals of treatment involve certain commonalities that characterize different therapeutic approaches and include *placing the traumatic experience in perspective* by helping the person gain control over the overwhelming emotions evoked by the memory of the event, and *achieving a differentiation between remembering and reliving* by stressing the difference between the past and present circumstances and increasing the person's awareness of the current, safer surroundings (Marmar, Foy, Kagan, & Pynoos, 1993). These goals are not realistic and may be counterproductive when the conditions of violence leading to traumatic stress responses are ongoing, because hypervigilance and other traumatic responses may be adaptive though costly mechanisms to increase personal safety. Attention to the conditions that increase safety and reduce risk must become the primary focus of the treatment in conditions of ongoing violence. Such a focus fosters progress towards another key goal of different therapeutic approaches to the treatment of trauma, namely, *fostering an increased capacity to respond realistically to threat* (Marmar et al., 1993).

The question of who may safely participate in the treatment needs careful evaluation. The literature on marital therapy indicates that couples' treatment may be hazardous when there is domestic violence because the therapeutic situation may generate a false sense of safety, leading to disclosures of intimate material that may trigger aggression when the violent partner feels aggrieved. In addition, some writers believe that couples' treatment must be

based on the premise that both partners are jointly responsible for the problems experienced by the couple, a premise that the nonoffending spouse is in some way responsible for her victimization (Edleson & Williams, 2007).

Although there are no systematic studies of whether child-focused family interventions may involve similar dangers, clinical experience working with violent parents indicates that, prior to agreeing to provide treatment in situations of ongoing domestic violence, it is essential to conduct careful evaluations of each parent's capacity to work productively with the other on behalf of the child. If a decision to provide treatment involving a violent parent is reached, explicit, preferably written, guidelines that are agreed upon by the parent and that define safety both in the therapeutic setting and in the home are an indispensable prerequisite for treatment. These safety guidelines should be upheld through at least four concrete measures. First, there should be formal involvement of the legal system, through the courts or child protective services, as overseers of the therapeutic contract with the violent parent. Second, the violent parent should be legally mandated to participate in a batterer's intervention program or other relevant individual or group treatment program, with a release of information form signed by the violent parent authorizing exchanges between that program and the child therapist about the parent's participation and progress in each treatment modality. Third, treatment must be conducted in a safe setting that includes ready access to a security guard who can be called using an easily reached "panic button" if the clinician feels the need for external support. Fourth, the violent parent should sign a written agreement to refrain from violent behavior during the sessions and to abide by agreed-upon behaviors when there is increased risk of violence in the home, such as leaving the home until it feels safe to return. These measures help to provide a safe framework that enhances the potential effectiveness of treatment by modeling concrete protective actions for the child and the parents and by increasing the therapist's sense of personal safety in conducting the treatment. The therapist's proactive stance in creating this safe framework represents a symbolic rebuilding of the protective shield for the child that was shattered by the domestic violence.

## CHALLENGES FOR THE THERAPIST

Vicarious traumatization of the therapist is an ever-present risk to effective treatment. Even seasoned clinicians may feel emotionally burdened and drained of their creative energy when confronted with situations that elicit horror and helplessness. Their effectiveness is undermined by uncontrollable emotional responses that may influence their therapeutic interventions, such as rescue fantasies involving the child, revenge fantasies involving the parents, pervasive fatigue, irritability, a judgmental attitude, or a persistent wish to terminate treatment. These responses can be moderated and contained when clinicians have readily available support systems that enable them to process their feelings with a trusted mentor or colleague. Therapists currently working in public health and community agencies face high case loads of children living in severely adverse circumstances with parents burdened by chronic trauma histories. These therapists do not as a rule have access to supervision and consultation in order to reflect and gather collegial feedback on the treatment plan and the progress of treatment. Frequent by-products of this situation are feelings of helplessness and a self-protective tendency to view complex clinical cases as intractable. Trauma treatment programs should insti-

tutionalize mentoring and supervision time for less experienced clinicians and allow time for reciprocal consultation and support for experienced clinicians as preventive steps to avoid or alleviate vicarious staff traumatization.

## EMPIRICAL EVIDENCE SUPPORTING CHILD-PARENT PSYCHOTHERAPIES

A growing body of research documents the efficacy of a therapeutic focus on the child-parent relationship to promote the mental health of infants, toddlers, and preschoolers. Improvements in domains such as attachment, self-representation, maternal representation, cognitive functioning, behavior problems, and post-traumatic stress disorder have been reported for young children with a range of risk factors, including infants in foster care (Dozier), anxiously attached Latino toddlers (Lieberman, Weston, & Pawl, 1991), toddlers of mothers with depression (Cicchetti, Toth, & Rogosh, 1999; Toth, Rogosch, & Cicchetti, in press), maltreated preschoolers in the child protective system (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002; Cicchetti, Rogosh, & Toth, 2006), and preschoolers who witnessed domestic violence (Lieberman, Van Horn, & Ghosh Ippen, 2005; Lieberman, Ghosh Ippen, & Van Horn, 2006). Lieberman & Van Horn (2005); Lieberman et al. (2006); also examined the efficacy of Child-Parent Psychotherapy with the battered mothers of the preschoolers who witnessed domestic violence, and found that in comparison with mothers referred for treatment in the community, the treatment-group mothers improved in symptoms and diagnosis of post-traumatic stress disorder at the end of treatment and continued to improve in symptoms of anxiety and depression at the time of follow-up six months after the termination of treatment. Taken together, these studies provide strong confirmation of the importance of focusing on the child-parent relationship in the treatment of early mental health disturbances, not only because of the value of this approach in improving child functioning but also because it is likely to promote the young child's long-term mental health by improving the mother's psychological functioning and hence her competence as a mother. It is important to note that four of these randomized trials involved predominantly ethnic minority samples, including Spanish-speaking dyads, suggesting that a relationship-based approach has ecological validity for different cultural groups.

## COLLABORATING ACROSS SERVICE SYSTEMS FOR TRAUMATIZED INFANTS AND YOUNG CHILDREN

Just as the child's individual functioning cannot be shored up without attention to the parents' needs, therapeutic intervention can achieve only limited success unless embedded in a collaborative framework with the larger systems involved with parents and children exposed to violence. The plight of children traumatized by violence is a supraclinical phenomenon because most such children and their parents are not served by the mental health programs but are found in a range of service delivery systems not equipped with clinical services commensurate to their needs, including pediatric care, childcare, schools, child protective services, the courts, and the penal system (Harris, Lieberman, & Marans, 2007). The ubiquitous presence of trauma among the consumers of these service systems highlights the importance for clini-

cians of becoming informed about and involved in partnerships with professionals and paraprofessionals across disciplines, institutions, agencies, associations, and government programs serving traumatized children and families at risk.

Two federally funded national initiatives will be highlighted here as having been designed to foster cross-system collaborations on behalf of traumatized children, including infants, toddlers, and preschoolers. The SAMHSA-funded National Child Traumatic Stress Network (NCTSN) comprises approximately 40 centers across the country that are charged with the mission of raising the standard of care and improving access to services for traumatized children, their families, and their communities. As a NCTSN center, the Early Trauma Treatment Network is a four-site collaborative designed specifically to address the needs of children in the birth–five age range. Comprising the Child Trauma Research Project at the University of California San Francisco, the Child Violence Exposure Program at Louisiana State University Health Science Center, the Child Witness to Violence Project at Boston Medical Center, and Tulane/Jefferson Parish Human Services Agency at Tulane University, the faculty and staff of these programs (directed, respectively, by Alicia Lieberman, Joy Osofsky, Betsy McAlister Groves, and Julie Larrieu and Charles Zeanah) have joined forces to provide training in early trauma and Child-Parent Psychotherapy, to adapt the principles of this treatment approach to the needs of service providers in pediatric care, childcare, mental health, child protective services, legal enforcement, and the courts, and to create products (manuals, brochures, handouts, and videotapes) that will enable the service providers in these systems to better identify, understand, and meet the needs of traumatized children in the birth-five age range and their families. The Safe Start Initiative is another federal initiative, funded by the Office of Juvenile Justice and Delinquency Prevention, that aims at promoting system change to foster collaboration and service integration among government entities, the legal system, and community agencies on behalf of children under six years of life exposed to violence. Child-Parent Psychotherapy is one of the treatments selected for training and dissemination in this federal program, with the goal of enhancing the ability of providers in the public mental health system and community agencies to offer services to young children and their families.

While laudable, creatively designed, and ably implemented, these and other national efforts do not operate at a sufficiently large scale to meet the enormous unmet needs of traumatized young children and their families across the country. The price of untreated childhood trauma in the forms of health and mental health costs, lost productivity, and crime is incalculable (Harris, Putnam, & Fairbank, 2006). A large study by Vincent Felitti and colleagues highlights the long-term consequences of childhood adversity. The Adverse Childhood Events (ACE) study (Felitti et al., 1998), conducted with more that 15,000 patients of Kaiser Permanente, one of the largest health providers in the country, found that there was a highly significant graded relationship between nine categories of traumatic childhood events and some of the leading causes of adult death and disability. The childhood adverse experiences measured by the study comprised psychological, physical, and sexual abuse; violence against the mother, living as a child with a household member who abused substances, was suicidal or mentally ill, or was ever imprisoned; absence of one or both parents; and physical or emotional neglect. Compared to individuals who had not experienced any of these nine adverse childhood events, respondents who had experienced four or more of these adversities had a fourfold to 12-fold increased likelihood of alcoholism, drug abuse, depression, and suicide attempts and a twofold to fourfold increased likelihood of smoking (including smok-

ing by age 14 and chronic smoking as adults) and sexually transmitted diseases. These health-risk behaviors serve as mediators between traumatic childhood events and the development of adult disease years later, including cardiovascular disease, cancer, liver disease, and lung disease.

The ACE findings converge with the findings of other research, including studies of twins that controlled for genetic factors, that make it manifestly clear that child maltreatment, family violence, and malfunction exact enormous mental, physical, and social costs over an individual's life (Kendler, Bulik, Silberg, Hettema, Myers, & Prescott, 2000). The prevalence of childhood abuse and other forms of trauma exposure involves such large numbers of children, and the sequelae of health and mental health disorder are so compelling that the situation can be characterized as a serious public health emergency that warrants a concerted mobilization of resources for these children and their families (Harris et al., 2006). Training of mental health professionals and paraprofessionals to identify and address childhood trauma, partnerships among the professionals and agencies serving children—including pediatric care providers, childcare providers, law enforcement officers, mental health professionals, child welfare workers, and judges and the legal profession—and bringing programs for underserved children to a scale commensurate with the need are basic public health strategies designed to protect the children, the families, and the society at large. The Reverend William Sloan Coffin at Yale enlarged and completed the dictum that power corrupts and absolute power corrupts absolutely by pointing out that powerlessness also corrupts, and absolute powerlessness does so absolutely, in the form of bitterness, cynicism, and failure to recognize and respect the experience of others, internal experiences that often find expression through violence in intimate relationships and in the public domain. In protecting children from these experiences, we are also protecting ourselves.

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